
SUBSTITUTE HOUSE BILL 1018

State of Washington

66th Legislature

2019 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Caldier, Cody, Jenkins, Santos, and Appleton)

READ FIRST TIME 02/08/19.

1 AN ACT Relating to fair dental insurance practices; amending RCW
2 48.43.005 and 48.43.740; adding new sections to chapter 48.43 RCW;
3 and creating a new section.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** (1) The legislature finds that in 2000,
6 the patient bill of rights was enacted to ensure that health insurers
7 use appropriate medical personnel to make health care decisions and
8 that enrollees have access to an impartial process for appealing an
9 insurer's decisions. To that end, the legislation required insurers
10 to have a utilization review program, prohibited insurers from
11 denying coverage for care that had prior authorization, required
12 insurers to have a comprehensive grievance process, and established
13 an independent review process for resolving disputes. The patient
14 bill of rights has been successful in protecting consumers by
15 establishing fair health insurance practices.

16 (2) The legislature further finds that the requirements of the
17 patient bill of rights do not apply to health plans that provide
18 dental only coverage. Insurers offering dental only coverage have
19 engaged in unfair practices that have harmed consumers, and consumers
20 have not had the necessary tools to challenge these practices.

1 Consumers deserve the same protections when accessing dental care as
2 when accessing medical care.

3 (3) The legislature, therefore, intends to curb abuses by dental
4 plans by extending the protections of the patient bill of rights to
5 health plans that offer dental only coverage, protecting health care
6 providers who advocate on behalf of their dental patients, and
7 prohibiting other unfair dental insurance practices.

8 **Sec. 2.** RCW 48.43.005 and 2016 c 65 s 2 are each amended to read
9 as follows:

10 Unless otherwise specifically provided, the definitions in this
11 section apply throughout this chapter.

12 (1) "Adjusted community rate" means the rating method used to
13 establish the premium for health plans adjusted to reflect
14 actuarially demonstrated differences in utilization or cost
15 attributable to geographic region, age, family size, and use of
16 wellness activities.

17 (2) "Adverse benefit determination" means a denial, reduction, or
18 termination of, or a failure to provide or make payment, in whole or
19 in part, for a benefit, including a denial, reduction, termination,
20 or failure to provide or make payment that is based on a
21 determination of an enrollee's or applicant's eligibility to
22 participate in a plan, and including, with respect to group health
23 plans, a denial, reduction, or termination of, or a failure to
24 provide or make payment, in whole or in part, for a benefit resulting
25 from the application of any utilization review, as well as a failure
26 to cover an item or service for which benefits are otherwise provided
27 because it is determined to be experimental or investigational or not
28 medically necessary or appropriate.

29 (3) "Applicant" means a person who applies for enrollment in an
30 individual health plan as the subscriber or an enrollee, or the
31 dependent or spouse of a subscriber or enrollee.

32 (4) "Basic health plan" means the plan described under chapter
33 70.47 RCW, as revised from time to time.

34 (5) "Basic health plan model plan" means a health plan as
35 required in RCW 70.47.060(2)(e).

36 (6) "Basic health plan services" means that schedule of covered
37 health services, including the description of how those benefits are
38 to be administered, that are required to be delivered to an enrollee
39 under the basic health plan, as revised from time to time.

1 (7) "Board" means the governing board of the Washington health
2 benefit exchange established in chapter 43.71 RCW.

3 (8) (a) For grandfathered health benefit plans issued before
4 January 1, 2014, and renewed thereafter, "catastrophic health plan"
5 means:

6 (i) In the case of a contract, agreement, or policy covering a
7 single enrollee, a health benefit plan requiring a calendar year
8 deductible of, at a minimum, one thousand seven hundred fifty dollars
9 and an annual out-of-pocket expense required to be paid under the
10 plan (other than for premiums) for covered benefits of at least three
11 thousand five hundred dollars, both amounts to be adjusted annually
12 by the insurance commissioner; and

13 (ii) In the case of a contract, agreement, or policy covering
14 more than one enrollee, a health benefit plan requiring a calendar
15 year deductible of, at a minimum, three thousand five hundred dollars
16 and an annual out-of-pocket expense required to be paid under the
17 plan (other than for premiums) for covered benefits of at least six
18 thousand dollars, both amounts to be adjusted annually by the
19 insurance commissioner.

20 (b) In July 2008, and in each July thereafter, the insurance
21 commissioner shall adjust the minimum deductible and out-of-pocket
22 expense required for a plan to qualify as a catastrophic plan to
23 reflect the percentage change in the consumer price index for medical
24 care for a preceding twelve months, as determined by the United
25 States department of labor. For a plan year beginning in 2014, the
26 out-of-pocket limits must be adjusted as specified in section
27 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
28 shall apply on the following January 1st.

29 (c) For health benefit plans issued on or after January 1, 2014,
30 "catastrophic health plan" means:

31 (i) A health benefit plan that meets the definition of
32 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
33 2010, as amended; or

34 (ii) A health benefit plan offered outside the exchange
35 marketplace that requires a calendar year deductible or out-of-pocket
36 expenses under the plan, other than for premiums, for covered
37 benefits, that meets or exceeds the commissioner's annual adjustment
38 under (b) of this subsection.

39 (9) "Certification" means a determination by a review
40 organization that an admission, extension of stay, or other health

1 care service or procedure has been reviewed and, based on the
2 information provided, meets the clinical requirements for medical
3 necessity, appropriateness, level of care, or effectiveness under the
4 auspices of the applicable health benefit plan.

5 (10) "Concurrent review" means utilization review conducted
6 during a patient's hospital stay or course of treatment.

7 (11) "Covered person" or "enrollee" means a person covered by a
8 health plan including an enrollee, subscriber, policyholder,
9 beneficiary of a group plan, or individual covered by any other
10 health plan.

11 (12) "Dependent" means, at a minimum, the enrollee's legal spouse
12 and dependent children who qualify for coverage under the enrollee's
13 health benefit plan.

14 (13) "Emergency medical condition" means a medical condition
15 manifesting itself by acute symptoms of sufficient severity,
16 including severe pain, such that a prudent layperson, who possesses
17 an average knowledge of health and medicine, could reasonably expect
18 the absence of immediate medical attention to result in a condition
19 (a) placing the health of the individual, or with respect to a
20 pregnant woman, the health of the woman or her unborn child, in
21 serious jeopardy, (b) serious impairment to bodily functions, or (c)
22 serious dysfunction of any bodily organ or part.

23 (14) "Emergency services" means a medical screening examination,
24 as required under section 1867 of the social security act (42 U.S.C.
25 1395dd), that is within the capability of the emergency department of
26 a hospital, including ancillary services routinely available to the
27 emergency department to evaluate that emergency medical condition,
28 and further medical examination and treatment, to the extent they are
29 within the capabilities of the staff and facilities available at the
30 hospital, as are required under section 1867 of the social security
31 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
32 respect to an emergency medical condition, has the meaning given in
33 section 1867(e)(3) of the social security act (42 U.S.C.
34 1395dd(e)(3)).

35 (15) "Employee" has the same meaning given to the term, as of
36 January 1, 2008, under section 3(6) of the federal employee
37 retirement income security act of 1974.

38 (16) "Enrollee point-of-service cost-sharing" means amounts paid
39 to health carriers directly providing services, health care

1 providers, or health care facilities by enrollees and may include
2 copayments, coinsurance, or deductibles.

3 (17) "Exchange" means the Washington health benefit exchange
4 established under chapter 43.71 RCW.

5 (18) "Final external review decision" means a determination by an
6 independent review organization at the conclusion of an external
7 review.

8 (19) "Final internal adverse benefit determination" means an
9 adverse benefit determination that has been upheld by a health plan
10 or carrier at the completion of the internal appeals process, or an
11 adverse benefit determination with respect to which the internal
12 appeals process has been exhausted under the exhaustion rules
13 described in RCW 48.43.530 and 48.43.535.

14 (20) "Grandfathered health plan" means a group health plan or an
15 individual health plan that under section 1251 of the patient
16 protection and affordable care act, P.L. 111-148 (2010) and as
17 amended by the health care and education reconciliation act, P.L.
18 111-152 (2010) is not subject to subtitles A or C of the act as
19 amended.

20 (21) "Grievance" means a written complaint submitted by or on
21 behalf of a covered person regarding service delivery issues other
22 than denial of payment for medical services or nonprovision of
23 medical services, including dissatisfaction with medical care,
24 waiting time for medical services, provider or staff attitude or
25 demeanor, or dissatisfaction with service provided by the health
26 carrier.

27 (22) "Health care facility" or "facility" means hospices licensed
28 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
29 rural health care facilities as defined in RCW 70.175.020,
30 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
31 licensed under chapter 18.51 RCW, community mental health centers
32 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
33 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
34 treatment, or surgical facilities licensed under chapter 70.41 RCW,
35 drug and alcohol treatment facilities licensed under chapter 70.96A
36 RCW, and home health agencies licensed under chapter 70.127 RCW, and
37 includes such facilities if owned and operated by a political
38 subdivision or instrumentality of the state and such other facilities
39 as required by federal law and implementing regulations.

40 (23) "Health care provider" or "provider" means:

1 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
2 practice health or health-related services or otherwise practicing
3 health care services in this state consistent with state law; or

4 (b) An employee or agent of a person described in (a) of this
5 subsection, acting in the course and scope of his or her employment.

6 (24) "Health care service" means that service offered or provided
7 by health care facilities and health care providers relating to the
8 prevention, cure, or treatment of illness, injury, or disease.

9 (25) "Health carrier" or "carrier" means a disability insurer
10 regulated under chapter 48.20 or 48.21 RCW, a health care service
11 contractor as defined in RCW 48.44.010, or a health maintenance
12 organization as defined in RCW 48.46.020, and includes "issuers" as
13 that term is used in the patient protection and affordable care act
14 (P.L. 111-148).

15 (26) (a) Except as provided in (b) of this subsection, "health
16 plan" or "health benefit plan" means any policy, contract, or
17 agreement offered by a health carrier to provide, arrange, reimburse,
18 or pay for health care services except the following:

19 ~~((a))~~ (i) Long-term care insurance governed by chapter 48.84 or
20 48.83 RCW;

21 ~~((b))~~ (ii) Medicare supplemental health insurance governed by
22 chapter 48.66 RCW;

23 ~~((c))~~ (iii) Coverage supplemental to the coverage provided
24 under chapter 55, Title 10, United States Code;

25 ~~((d))~~ (iv) Limited health care services offered by limited
26 health care service contractors in accordance with RCW 48.44.035;

27 ~~((e))~~ (v) Disability income;

28 ~~((f))~~ (vi) Coverage incidental to a property/casualty liability
29 insurance policy such as automobile personal injury protection
30 coverage and homeowner guest medical;

31 ~~((g))~~ (vii) Workers' compensation coverage;

32 ~~((h))~~ (viii) Accident only coverage;

33 ~~((i))~~ (ix) Specified disease or illness-triggered fixed payment
34 insurance, hospital confinement fixed payment insurance, or other
35 fixed payment insurance offered as an independent, noncoordinated
36 benefit;

37 ~~((j))~~ (x) Employer-sponsored self-funded health plans;

38 ~~((k))~~ (xi) Dental only and vision only coverage;

39 ~~((l))~~ (xii) Plans deemed by the insurance commissioner to have
40 a short-term limited purpose or duration, or to be a student-only

1 plan that is guaranteed renewable while the covered person is
2 enrolled as a regular full-time undergraduate or graduate student at
3 an accredited higher education institution, after a written request
4 for such classification by the carrier and subsequent written
5 approval by the insurance commissioner; and

6 ~~((m))~~ (xiii) Civilian health and medical program for the
7 veterans affairs administration (CHAMPVA).

8 (b) For purposes of RCW 48.43.520, 48.43.525, 48.43.530, and
9 48.43.535, "health plan" or "health benefit plan" also includes a
10 dental only plan offered after December 31, 2019, but does not
11 include fully capitated dental plans.

12 (27) "Individual market" means the market for health insurance
13 coverage offered to individuals other than in connection with a group
14 health plan.

15 (28) "Material modification" means a change in the actuarial
16 value of the health plan as modified of more than five percent but
17 less than fifteen percent.

18 (29) "Open enrollment" means a period of time as defined in rule
19 to be held at the same time each year, during which applicants may
20 enroll in a carrier's individual health benefit plan without being
21 subject to health screening or otherwise required to provide evidence
22 of insurability as a condition for enrollment.

23 (30) "Preexisting condition" means any medical condition,
24 illness, or injury that existed any time prior to the effective date
25 of coverage.

26 (31) "Premium" means all sums charged, received, or deposited by
27 a health carrier as consideration for a health plan or the
28 continuance of a health plan. Any assessment or any "membership,"
29 "policy," "contract," "service," or similar fee or charge made by a
30 health carrier in consideration for a health plan is deemed part of
31 the premium. "Premium" shall not include amounts paid as enrollee
32 point-of-service cost-sharing.

33 (32) "Review organization" means a disability insurer regulated
34 under chapter 48.20 or 48.21 RCW, health care service contractor as
35 defined in RCW 48.44.010, or health maintenance organization as
36 defined in RCW 48.46.020, and entities affiliated with, under
37 contract with, or acting on behalf of a health carrier to perform a
38 utilization review.

39 (33) "Small employer" or "small group" means any person, firm,
40 corporation, partnership, association, political subdivision, sole

1 proprietor, or self-employed individual that is actively engaged in
2 business that employed an average of at least one but no more than
3 fifty employees, during the previous calendar year and employed at
4 least one employee on the first day of the plan year, is not formed
5 primarily for purposes of buying health insurance, and in which a
6 bona fide employer-employee relationship exists. In determining the
7 number of employees, companies that are affiliated companies, or that
8 are eligible to file a combined tax return for purposes of taxation
9 by this state, shall be considered an employer. Subsequent to the
10 issuance of a health plan to a small employer and for the purpose of
11 determining eligibility, the size of a small employer shall be
12 determined annually. Except as otherwise specifically provided, a
13 small employer shall continue to be considered a small employer until
14 the plan anniversary following the date the small employer no longer
15 meets the requirements of this definition. A self-employed individual
16 or sole proprietor who is covered as a group of one must also: (a)
17 Have been employed by the same small employer or small group for at
18 least twelve months prior to application for small group coverage,
19 and (b) verify that he or she derived at least seventy-five percent
20 of his or her income from a trade or business through which the
21 individual or sole proprietor has attempted to earn taxable income
22 and for which he or she has filed the appropriate internal revenue
23 service form 1040, schedule C or F, for the previous taxable year,
24 except a self-employed individual or sole proprietor in an
25 agricultural trade or business, must have derived at least fifty-one
26 percent of his or her income from the trade or business through which
27 the individual or sole proprietor has attempted to earn taxable
28 income and for which he or she has filed the appropriate internal
29 revenue service form 1040, for the previous taxable year.

30 (34) "Special enrollment" means a defined period of time of not
31 less than thirty-one days, triggered by a specific qualifying event
32 experienced by the applicant, during which applicants may enroll in
33 the carrier's individual health benefit plan without being subject to
34 health screening or otherwise required to provide evidence of
35 insurability as a condition for enrollment.

36 (35) "Standard health questionnaire" means the standard health
37 questionnaire designated under chapter 48.41 RCW.

38 (36) "Utilization review" means the prospective, concurrent, or
39 retrospective assessment of the necessity and appropriateness of the
40 allocation of health care resources and services of a provider or

1 facility, given or proposed to be given to an enrollee or group of
2 enrollees.

3 (37) "Wellness activity" means an explicit program of an activity
4 consistent with department of health guidelines, such as, smoking
5 cessation, injury and accident prevention, reduction of alcohol
6 misuse, appropriate weight reduction, exercise, automobile and
7 motorcycle safety, blood cholesterol reduction, and nutrition
8 education for the purpose of improving enrollee health status and
9 reducing health service costs.

10 **Sec. 3.** RCW 48.43.740 and 2015 c 9 s 1 are each amended to read
11 as follows:

12 (1) A health carrier offering a dental only plan may not:

13 (a) Deny coverage for treatment of emergency dental conditions
14 that would otherwise be considered a covered service of an existing
15 benefit contract on the basis that the services were provided on the
16 same day the covered person was examined and diagnosed for the
17 emergency dental condition;

18 (b) Take or threaten to take punitive action against a provider
19 acting on behalf of or in support of a covered person because the
20 provider disputes the carrier's determination with respect to
21 coverage or payment for a dental service; or

22 (c) Deny a claim for a covered dental service provided by a
23 treating dentist to a covered person. If the carrier denies a claim
24 for such a service, the carrier may not advertise in promotional
25 materials or an explanation of benefits sent to prospective or
26 current members that the carrier covers the dental service.

27 (2) For purposes of this section:

28 (a) "Emergency dental condition" means a dental condition
29 manifesting itself by acute symptoms of sufficient severity,
30 including severe pain or infection such that a prudent layperson, who
31 possesses an average knowledge of health and dentistry, could
32 reasonably expect the absence of immediate dental attention to result
33 in:

34 (i) Placing the health of the individual, or with respect to a
35 pregnant woman the health of the woman or her unborn child, in
36 serious jeopardy;

37 (ii) Serious impairment to bodily functions; or

38 (iii) Serious dysfunction of any bodily organ or part.

1 (b) "Health carrier," in addition to the definition in RCW
2 48.43.005, also includes health care service contractors, limited
3 health care service contractors, and disability insurers offering
4 dental only coverage.

5 (3) This section does not apply to fully capitated dental plans.

6 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43
7 RCW to read as follows:

8 (1) Beginning October 1, 2019, and annually thereafter, a health
9 carrier offering a dental only plan shall annually submit to the
10 commissioner the explanation of benefits form the carrier plans to
11 use for the dental only plan for the subsequent plan year. The
12 submission must also include a list of standard definitions and terms
13 the carrier will use on the form and an example of a completed form.

14 (2) Using the forms it receives under subsection (1) of this
15 section in 2019, the commissioner shall adopt rules setting minimum
16 standards for the format, terms, and definitions for explanation of
17 benefits forms used for dental only plans. The rules must also
18 include a model explanation of benefits form, model terms, and model
19 definitions. The commissioner must adopt the rules required under
20 this subsection no later than July 1, 2020.

21 (3) Beginning with submissions received for plan year 2021:

22 (a) The commissioner may disapprove of an explanation of benefits
23 form, or the standard definitions or terms used on that form,
24 submitted under subsection (1) of this section if the commissioner
25 finds the form, definitions, or terms are confusing, inconsistent, or
26 misleading;

27 (b) The commissioner may not disapprove of a form, terms, or
28 definitions if they are substantially identical to the model form,
29 terms, and definitions adopted under subsection (2) of this section;
30 and

31 (c) A health carrier offering a dental only plan may not use an
32 explanation of benefits form, or standard definitions or terms for
33 use on that form, if the commissioner has disapproved of the form,
34 definitions, or terms.

35 (4) For purposes of this section, "health carrier," in addition
36 to the definition in RCW 48.43.005, also includes health care service
37 contractors, limited health care service contractors, and disability
38 insurers offering dental only coverage.

39 (5) This section does not apply to fully capitated dental plans.

1 NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43
2 RCW to read as follows:

3 (1) Health benefit plans, health care service contractors, or
4 health carriers offering dental benefits may not deny or limit
5 coverage based on an individual's oral health condition, including
6 situations in which a tooth is missing at the time coverage starts
7 with the carrier.

8 (2) For the purposes of this section:

9 (a) "Health benefit plan" has the same meaning as provided in RCW
10 48.43.005.

11 (b) "Health care service contractor" and "health carrier" have
12 the same meaning as "health carrier" defined in RCW 48.43.005.

13 (3) This section does not apply to fully capitated dental plans.

--- END ---